Underwriters, Independent Agent, and Health Plan Comments

Amerigroup

D&S Agency Inc.

DentaQuest

Delta Dental

Virginia Association of Health Plans

Optima Health

UnitedHealth Group

National Association of Health Underwriters

Anthem

Independent Insurance Agents of Virginia

Kaiser Permanente

August 26, 2011

Cindi B. Jones
Director, Virginia Health Reform Initiative
Office of the Secretary of Health and Human Resources
Commonwealth of Virginia
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

Re. Amerigroup Comments on Third Background Memorandum on Health Benefit Exchange Issues: Preparing for Potential 2012 Health Benefit Exchange Legislation

Dear Director Jones:

Thank you for the opportunity to comment on the Virginia Health Reform Initiative's (VHRI's) third background memorandum on Health Benefit Exchange (HBE) issues. Because of our unique experience serving public health care program beneficiaries, we are pleased to share our thinking on opportunities to ensure seamless, coordinated care as these individuals look to the HBE in future years for coverage.

Amerigroup Virginia is a wholly owned subsidiary of Amerigroup Corporation, the largest publicly traded company focused exclusively on the health care needs of Medicaid recipients and the uninsured. Amerigroup Corporation owns health care subsidiaries providing Medicaid coordinated care services to approximately 2 million members in 11 states. Amerigroup Virginia serves more than 40,000 Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP) and Supplemental Security Income/Aged, Blind and Disabled (SSI/ABD) members through the Medallion II (Medicaid/FAMIS Plus) and FAMIS programs in the commonwealth of Virginia.

Comments on Preparing for Potential 2012 Health Benefit Exchange Legislation

Section V of the VHRI's third background memorandum specifically requested comments on where the lines of responsibilities should be drawn for decision making on HBE issues between the General Assembly, HBE governing board, and HBE executive director. Clearly each of the three entities has an inextricably significant role in this process, however Amerigroup believes that there are certain fundamental considerations that should inform the recommendations made by the VHRI Advisory Council on the delineation of HBE responsibilities and/or the scope of potential HBE legislation in 2012.

As evidenced by the very existence of the VHRI, and the General Assembly's request in House Bill 2434 for HBE policy recommendations, occasionally there are circumstances and issues that can be most effectively addressed by non-legislative, apolitical bodies, with the legislature providing initial authorization and ongoing oversight. Amerigroup believes that due to the complexity of the issues involved, the restraints of the externally imposed timeline, and the resultant practical implications of both (e.g., progress requirements for federal grant funds; need for sufficient time for stakeholder

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engagement; ability to focus exclusively on the extensive policy issues and operational details), the establishment of the Virginia HBE should follow a similar process. Broadly speaking, the model HBE legislation proposed by the National Association of Insurance Commissioners, as well as the experience and legislation of several other states, provide useful reference points.

The Basic Health Program

As discussed in Section VI of the background memorandum, the impending scenario in which many individuals will frequently experience eligibility shifts between Medicaid and the HBE due to relatively small fluctuations in incomes, often referred to as "churn", presents significant challenges to the Commonwealth's goals for both programs. Similarly, the ensuing discontinuity of coverage for the individuals affected would likely reduce access to needed care, particularly in the most appropriate setting, potentially resulting in negative health outcomes and higher medical costs. Amerigroup strongly believes that the BHP is a very promising option to mitigate the impacts of churn, reduce state administrative burdens and promote affordable coverage for low-income individuals.

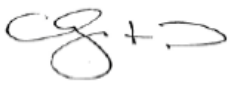
Amerigroup certainly understands the concerns raised in Section VI regarding the potential impact of the BHP on administrative resources that are already scarce during the current state budget difficulties. However, it is important to keep in mind that if unaddressed, the churn issue will also result in strains on administrative resources. Additionally, and perhaps more critically, the harmful consequences on access to care and health outcomes of churn-related discontinuity of coverage would likely result in increased costs to the Commonwealth. Potential examples include higher rates of avoidable emergency room utilization, gaps in preventive care, and disruptions of doctor-patient relationships, as well as disease management efforts.

Amerigroup believes that by drawing upon its successful experience in Medicaid managed care and leveraging the existing capabilities and processes, the Commonwealth could implement a BHP in a manner that would minimize administrative and programmatic costs, while largely addressing the issue of churn. Regardless of the Commonwealth's ultimate decision on the BHP option, as the only health plan in Virginia focused exclusively on public health programs, Amerigroup is eager to utilize our experience and expertise related to addressing the health care needs of low-income individuals in working with our state partners to successfully navigate these challenges.

In closing, we would like to emphasize Amerigroup Virginia's support for the Commonwealth's decision to proactively meet the challenges and opportunities presented by the task of establishing and operating a state-based HBE, especially in a manner that engages stakeholder input, perspective and expertise.

On behalf of Amerigroup Virginia and Amerigroup Corporation, thank you again for the opportunity to comment on the VHRI's third Background Memorandum on HBE issues. We look forward to continuing to work with you on these important issues.

Sincerely,



Kit Gorton, MD

Chief Executive Officer
Amerigroup Virginia

CC: James G. Carlson, Chairman and Chief Executive Officer, Amerigroup Corporation
and Council Member, Virginia Health Reform Initiative Advisory Council
Lindsay Berry, Director of Government Relations, Amerigroup Virginia

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August 26, 2011

Ms. Cindi B. Jones
Director of Virginia Health Reform Initiative
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RE: Comments on September 9 Memorandum on Preparing for Potential 2012 Health Benefit Exchange legislation

Dear Ms. Jones:

From the July 15th presentation by the Urban Institute to VHRI, of the 6,929,000 non-elderly Virginians, roughly 1,036,461 are uninsured. As can be deduced from page seven of that presentation, some groups included in this number simply are not interested in having care. Brokers can attest to this from group health plan enrollment where employers offer health coverage for as little as $5 per pay period. Some Virginians simply will not purchase health care, regardless of the cost as can be verified from the Massachusetts plan which is operating at a 98.1% participation rate where coverage is supposedly mandatory!

For many many years small employers have provided voluntary group health benefits to their employees for several reasons. Small employers view employees as just part of the family. Small employers take care of their own because it is the right thing to do. As 2014 nears many of these small business owners are losing their moral imperative and voluntary nature of taking care of their own. Now they are being told they have to provide coverage and that one point will increase the utilization of health care and make exchanges a very viable option. Although we think the Urban Institute's presentation to be very well done, their possible enrollment numbers of between 450,000 and 1,000,000 will be woefully short and here is why.

PPACA penalties to employers with 50 or more employees are only $2000 per employee per year. If an employer had exactly 50 full time employees the "Free Rider" Penalty tax allows that employer to subtract 30 workers from the calculation. If the employer has an annual cost for their group health coverage of $8,688 per employee, the current national average, do you think an employer would ever consider saving $434,000 in annual premiums, pay $40,000 in penalties, take this nearly 400,000 savings and gross up employees pay $200,000 (employees would love that) and send employees off to exchange and individual coverage land and still save $200,000? The world of you have to compared to the world of the right thing are vastly different in anyone's eye!

In Roanoke Virginia we just don't have many jobs that pay $43,560 which is 400% of the Federal Poverty Level. These employees will be eligible to purchase health care within the exchange and subsidize that cost through the use of "Free Choice" vouchers. Participation in group health plans will not be eligible for "Free Choice" vouchers.

Finally, group health plans have not had pre-existing limitations since HIPAA in 1997. Employees who were unable to secure health coverage because of medical underwriting requirements did not have an issue receiving coverage through an employer group health plan. In 2014 medical underwriting will no longer exist and another reason employer's had in offering a group health plan, to help their employees, will be gone.

Exchanges will grow from 2-50 to 2-100 in 2016. In 2017 don't be surprised for pressure, nationally, to take them into the larger market as well.

We feel Exchanges will become a large ticket item for the Commonwealth, an expense so large no one will be able to comprehend. Anything the committee can do to limit coverage within the exchange or to help in the continuation of a viable group health market is critical.

All but about 14 million medical uninsured Americans have survived with our current voluntary delivery system. Unfortunately that system has been ridiculously expensive as a result of many contributing factors. We hope the Virginia Exchange does not take the same financial path as Massachusetts which has been horribly expensive just to insure a relatively few additional citizens.

Sincerely,

William L. Kite, Jr.
Benefit Advisor

DentaQuest

August 26, 2011

Cynthia B. Jones, Director
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Len M. Nichols, PhD
Center for Health Policy Research & Ethics
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Dear Ms. Jones and Dr. Nichols:

DentaQuest is pleased to file comments on the third background memorandum on health benefit exchange issues. We are proud to engage in this critical discussion and provide assistance to the Commonwealth on oral health issues. Here, we provide comments only on specific sections of the memorandum as noted.

Background

DentaQuest partners with the Commonwealth to ensure that nearly 900,000 Virginians access oral health care. We do this by administering the Medicaid/FAMIS dental program, *Smiles for Children*, in partnership with the Commonwealth. Recently, the Commonwealth of Virginia renewed DentaQuest's contract to administer the *Smiles for Children* program at least until June 30, 2015. Additionally, DentaQuest provides commercial dental benefits to small groups and individuals – nearly 20,000 individuals primarily in Northern Virginia. DentaQuest looks forward to playing a critical role on the exchange.

Section IV: "Clarification of the Potential Role of the Bureau of Insurance and the Health Benefits Exchange"

As the memo addresses the role of the Bureau of Insurance and the Health Benefits Exchange, several critical issues are raised. Here, we highlight additional issues which must be addressed when considering dental plans and their role on the exchange.

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1. Qualified Dental Plans

In the memorandum, the issue of how qualified health plans will be reviewed and certified is a key focus. In addition to qualified health plans, the chart provided references stand alone dental plans. The *Affordable Care Act* requires states to offer stand alone dental plans on exchanges, either separately or in conjunction with a qualified health plan.

We appreciate that the Commonwealth is not immediately faced with a policy decision regarding dental plans. However, as the Commonwealth addresses this issue, DentaQuest urges policymakers to allow stand alone dental plans to separately sell dental products on the exchange. Exchange customers will have greater awareness of dental coverage, and may be more likely to utilize these preventive benefits, if the exchange allows benefits to be separately priced and sold.

2. Requirements of Qualified Dental Plans

The memorandum specifically references the operating requirements that qualified health plans must abide by when operating on the exchange. Here again, it is important to note that the Commonwealth's requirements for stand alone dental plans will be unique. *The Affordable Care Act* and the *Health Insurance Portability and Accountability Act* establish stand alone dental plans as "excepted benefits," acknowledging that they are significantly different from medical carriers. As such, market rules applicable to stand alone medical carriers are generally not applicable to stand alone dental plans. As the Commonwealth assesses exchange requirements, DentaQuest looks forward to working with you to determine the appropriate requirements for dental plans while acknowledging the unique nature of these carriers.

Section V: "Decisions that could be made by the Legislature, the Governance Structure, and the Director of the Health Benefits Exchange"

The memorandum comprehensively lays out the key issues necessary for *Affordable Care Act* implementation and suggests responsibilities for those issues. Here, we acknowledge how dental issues may fit into this detailed framework.

1. Medicaid Coordination

In order to qualify for a Level Two Establishment grant, the memo acknowledges the necessity of coordination with the State Medicaid Agency. Clearly the Commonwealth has engaged in this effort and we applaud this effort. DentaQuest would like to acknowledge the future importance of coordination and discussion on specific policy issues. As the Commonwealth's partner on dental benefits administration, we look forward to initiating conversations with the agency on the coordination of pediatric dental benefits on the exchange, as well as those covered by *Smiles for Children*.

2. Composition of Board

We agree it is appropriate for the Legislature to address governance of the exchange board. As the Legislature addresses this issue, DentaQuest suggests an assessment of the capabilities necessary on the governing board. Because qualified dental plans will operate on the exchange, we suggest oral health expertise is a critical capability.

3. Key Exchange Functionality – comparative plan information

As the memo details the functions required to be compliant with the *Affordable Care Act*, the importance of transparency is mentioned. Specifically noted is the need for an exchange board to establish "a Website with comparative plan information, ombudsman, toll free hotline, Navigator program, cost calculator, value ranking, etc." It is important to note that the Commonwealth will have to address this issue not only for medical carriers, but also stand alone dental plans. For example, we urge the Commonwealth to ensure that tools such as cost calculators allow for evaluation not only of medical product offerings, but also dental offerings.

Section VI: "The Basic Health Plan"

The memo invites comments on the value of creating a Virginia-specific version of the "basic health plan." We believe that there may be merit to considering this approach in order to streamline care for individuals that hover around Medicaid's income eligibility level; this option may create greater continuity of coverage and care. However, we acknowledge the complexity of this issue. The Commonwealth must address whether the federal funding supplied for this initiative – 95 percent of federal tax credits and subsidies – is sufficient and whether the resources to implement and administer such a program are available.

To the extent that the Commonwealth decides to move forward with a Basic Health Plan, we urge policymakers to consider how dental benefits would be administered in the plan. We recommend a parallel track with Medicaid – specifically that a competitive process be followed to contract with a dental plan that can administer Basic Health Plan dental benefits. This is a system that works for Medicaid and should be replicated if the Basic Health Plan is created.

Thank you for the opportunity to not only file comments on these important issues, but engage in a dialogue about the creation of the health benefits exchange. If you have questions about the issues raised here, please contact Claudine Swartz at 616-886-1181.

Sincerely,

Claudine Swartz
Vice President, Government Relations

cc: Insurance Commissioner Jacqueline Cunningham
Mark Haraway, Regional VP, DentaQuest
Dennis Leonard, President and Chief Sales Officer, DentaQuest
Pat Finnerty

DELTA DENTAL

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August 26, 2011

Cindi B. Jones, Director, Virginia Health Reform Initiative, Office of the Secretary of Health and Human Resources

Len M. Nichols, Ph.D., Director, Center for Health Policy Research and Ethics, George Mason University

Virginia Health Reform Initiative Advisory Council and Task Force Members

SUBJECT: DDVA's Response to Third Background Memorandum on Health Benefit Exchange Issues - Topic: Preparing for Potential 2012 Health Benefits Exchange Legislation

Dear Ms. Jones, Dr. Nichols, and Members of the VHRI Advisory Council and Task Forces:

Delta Dental of Virginia ("DDVA") appreciates the opportunity to comment on the third white paper on exchange development and implementation in the Commonwealth. As you may recall from our prior submission, DDVA is a not-for-profit, non-stock corporation that provides prepaid dental services benefits for groups and individuals. We cover more than 1.6 million enrollees in over 3,700 businesses and organizations ranging from 2 to 100,000 employees. Included are more than 250 local government groups and school systems and 7,000 individual members. Our individual members are self-employed business owners, retirees, and others without access to dental benefits through their employers.

You asked for public comment on where 2012 health benefit exchange ("HBE") legislation should draw the lines of responsibility in three areas: legislative, governing board, and executive director. In general terms, we support the principles developed by the Virginia Association of Health Plans; we participated in that process. DDVA offers these further comments and suggestions:

1. Major decisions that must be addressed by the General Assembly

   DDVA's Response: The General Assembly should set broad public policy and direction that promotes competition; enhances consumer choice; provides for a stable, self-sustaining HBE for individual and small group purchasers and qualified health plans ("QHPs"); facilitates ease of enrollment in and disenrollment from the HBE; and does not disrupt existing markets for those consumers who are not affected by the federal Affordable Care Act ("ACA"). To these ends, the 2012 HBE legislation should clearly state that:

   a. The Commonwealth adopts a facilitator model, and the exchange will promote competition among a wide range of carriers that meet all federally-mandated requirements for QHPs.

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b. There will be one state-wide exchange for all HBE oversight and administrative functions, with QHPs able to structure networks and rate products geographically within the state.

c. The Commonwealth supports robust competition in the exchange so that consumers whom the HBE will benefit may choose from a wide range of affordable major medical and dental policy options and compare these options on the basis of price, benefits, breadth of network coverage, and quality.

d. The Commonwealth will utilize existing state agency-level capabilities where and when available and subcontract out those areas for which the HBE does not have, or seek to acquire, relevant expertise. The state agencies that retain specific authority and the scope of their authority must be specified in the legislation.

e. There is a clearly defined role for navigators, meaning that the HBE will use community-based resources if and where these resources are available, properly trained, and accredited. The legislation should include language that acknowledges there is a continuing role for health insurance brokers and agents both inside and outside the exchange.

2. Major policy decisions that should be delegated entirely to the Governing Board

DDVA's Response: We believe that some of the responsibilities listed in the third white paper which are potentially assigned to the Governing Board are more appropriately retained by the General Assembly (e.g., where to "house" the HBE, whether the Board is "Governing or Advisory," and defining what a "small group" is). The 2012 legislation should specify that the HBE Governing Board's role is two-fold: (i) oversight of all exchange functions not specifically retained by the federal government, the General Assembly, and existing state agencies in the manner provided for in the legislation itself; and (ii) on-going advice (including proposals for legislative changes) to the General Assembly, the Governor, the Secretary, and the Executive Director on all matters relating to the operation of the HBE in Virginia. In addition, the 2012 HBE legislation should provide that:

a. The HBE governing body will be geographically diverse and broadly representative of those served by, and those who will potentially serve, the HBE. Acknowledging the ACA's requirement to offer stand-alone dental plans in the HBEs, provision should be made for a Governing Board that includes at least one individual with a high-level of expertise in areas relevant to dental insurance markets and preferences of dental benefits group decision-makers and individual purchasers.

b. All policies of the HBE should promote and facilitate transparency at the purchaser level. In other words, as we urged in our June 29th letter, purchasers and potential purchasers should understand what they are buying and how much it costs. The legislation should specifically acknowledge that the dental benefits market has special characteristics, which include the separate pricing and separate offer of the benefits and administration of separate dental networks, that differ from those in the major medical market.

c. QHPs are encouraged to develop and offer innovative wellness and other disease management programs that will benefit existing and potential insureds, both inside and outside the exchange, even if these programs are not expressly provided for as part of the federal government's essential benefits package.

d. Federal subsidies can, and should, be used for the purchase of pediatric dental benefits in the HBE.

3. Major policy decisions that should be delegated to the Executive Director

DDVA's Response: With policy guidance and direction from the General Assembly, and on-going oversight and advice from the Governing Board, the HBEs Executive Director should hire the HBE staff, manage the internal planning processes, develop specific long-term and short-term objectives, report results publicly, and manage the day-to-day operations of the HBE. In addition to the Executive Director's other responsibilities listed in the third white paper, the Executive Director should:

a. Develop annual or bi-annual budgets, to be approved by the Governing Board, that clearly provide for participating QHP fees well in advance of their effective dates, areas of responsibility for which the HBE will maintain or seek to acquire in-house expertise, and areas that the HBE will subcontract out to qualified vendors.

b. Ensure that the web-based exchange system is designed and built to facilitate open, comparative shopping by potential purchasers. As noted in our previous response, RFPs should be crafted so that stand-alone dental plan options are readily available and easily identifiable as part of the online shopping interface. By doing that, the HBE will avoid costly systems and technology changes later. The national Delta Dental Plans Association has developed and DDVA will share, at a more appropriate time, a template which accomplishes this result.

Please let me know if you have questions and wish us to provide further information. We look forward to continuing to work with you and others to develop a truly superior HBE for the Commonwealth.

Sincerely,

George A. Levicki, DDS
President & CEO

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August 26, 2011

Ms. Cindi B. Jones
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Dr. Len Nichols
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Dear Ms. Jones, Dr. Nichols, and members of the Virginia Health Reform Advisory Council:

As states across the nation grapple with the requirements and implications of the Patient Protection and Affordable Care Act (PPACA) the Virginia Association of Health Plans (VAHP) appreciates the work you have done in addressing many of these issues through the Virginia Health Reform Initiative (VHRI). We also look forward to working with you, the State Corporation Commission's Bureau of Insurance (BOI), and other stakeholders as you sort through the design details of Virginia's exchange.

The August 12, 2011 memorandum entitled "Third Background Memorandum on Health Benefit Exchange Issues – Topic: Preparing for Potential 2012 Health Benefit Exchange Legislation", highlights many of the policy issues surrounding the exchange that have yet to be answered. As the conversation surrounding Virginia's exchange continues, we reiterate our support of a facilitator model that continues the Commonwealth's historical respect for competition and also recognizes the General Assembly's policy making role in the insurance market.

Facilitator Model

Virginia's repeated rankings as the business friendliest state highlights the Commonwealth's long tradition of supporting competition and the use of market forces. A facilitator exchange model best conforms to this practice and environment.

A facilitator exchange would:

- Permit all plans that meet exchange criteria to participate;
- Allow the market to drive plan selection and enrollment;
- Not selectively contract and exclude plans that meet the requirements for participation; and
- Focus on the market within the exchange.

The VAHP believes having Virginia's exchange serve as a facilitator, is key to encouraging competition, innovation, and choice for consumers and employers. As outlined in our third exchange principle:

> *Principle 3: Virginia's exchange should serve as a facilitator and not an active purchaser.*

Health plans must currently meet the basic standards for licensure and certification from the Bureau of Insurance (BOI) and the Department of Health (VDH). Plans must be licensed by the BOI as either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). In addition, they must be certified by VDH as a Managed Care Health Insurance Plan (MCHIP). The Code of Virginia citations highlighted below and attached ensure financial solvency, quality, and provider access.

- Title 38.2 Insurance, Chapter 13 Reports, Reserves and Examinations, Insurance Holding Companies, Reinsurance Intermediaries.
- Title 32.1 Health, Chapter 5 Regulation of Medical Care Facilities and Services.

All of VAHP's members go beyond the basic standards established by statute and are accredited by the National Committee for Quality Assurance (NCQA). NCQA is a nationally recognized independent accrediting body that conducts rigorous and comprehensive evaluations of the quality of health plan systems, processes, and results. To ensure quality services are rendered, plans are evaluated on a number of measures including:

- Quality Management and Improvement;
- Utilization Management;
- Credentialing and Recredentialing ;
- Members' Rights and Responsibilities;
- Standards for Member Connections ;
- Medicaid Benefits and Services ; and
- HEDIS/CAHPS Performance Measures.

In addition, federal health reform will add additional rules that health plans must comply with that are outlined later in this letter.

To go beyond the anticipated federal and state requirements and voluntary standards is unnecessary. However, if the Commonwealth wishes to pursue further regulation, we feel this decision is best made by the General Assembly.

Exchange Policy vs. Administration

The General Assembly is the ultimate maker of public policy in Virginia. The laws passed by the General Assembly set the policy for the health insurance market in Virginia. The regulations created by administrators define the details of the program to ensure expectations are met. The regulatory process enables all parties to participate. This process will apply to Virginia's exchange as well.

- As a proponent of the facilitator model, we largely support the General Assembly making policy with the exchange administering that policy.
- Administrative oversight of exchange operations to ensure compliance with federal and state regulations should be the purview of the exchange and executive director.
- The creation and implementation of an exchange is a long journey with many steps. Administering the exchange itself is a colossal undertaking and should be the primary focus of the exchange entity and executive director.

Many may underestimate the administrative load that the exchange must undertake.

- The administrative burden of implementing and operating an exchange is substantial. To add major policy decisions to this mix at the outset is too much for this new undertaking. To highlight the administrative complexity alone, below is a list of recently released federal regulations that the exchange must administer:
    - CMS-9989-P: Establishment of Exchanges and Qualified Health Plans (62 pages)
    - CMS-9975-P: Standards Related to Reinsurance, Risks Corridors and Risk Adjustment (27 pages)
    - CMS-9989-P2: Preliminary Regulatory Impact Analysis: Establishment of Exchanges and Qualified Health Plans (CMS-9989-P) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-P) (45 pages)
    - CMS-9974-P: Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers (139 pages)
    - Medicaid Program; eligibility Changes under the Affordable Care Act of 2010 (203 pages)
    - Health Insurance Premium Tax Credits (67 pages)
    - Further regulations are expected on the Essential Health Benefit, Quality Standards, etc.

- Federal reform imposes substantial regulations on health plan design and other components of the marketplace. This necessarily limits opportunities available for a state exchange to go beyond federal standards without greatly increasing premiums.
    - End of health underwriting.
    - Medical loss ratio limits.
    - Actuarial values.
    - Out-of-pocket costs capped.
    - Essential benefits.
    - Lifetime and annual dollar limits prohibited.

- The exchange's coordinating responsibilities with existing state agencies are daunting.
    - Bureau of Insurance – health plan licensure and certification of plans (solvency, appeals, etc.).
    - Department of Health – MCHIP certification (network adequacy etc.).
    - Department of Social Services – Medicaid eligibility.
    - Department of Medical Assistance Services – Medicaid.
    - Virginia Employment Commission.
    - Department of Taxation.
    - Department of Motor Vehicles – identification, etc.

The General Assembly's policy decisions will support a more seamless exchange structure and administration as multiple agencies look to support the functions of an exchange within their current and future responsibilities. For example, as outlined in two of our exchange principles below and in the memo, many of the functions of an exchange are currently handled by the State Corporation Commission and the Department of Health.

> *Principle 4: Regulatory oversight of products sold in the exchange should remain with the BOI and should not be given to the exchange.*
>
> *Principle 16: To the extent that they exist, standards and assessments of qualified health plans that are currently in practice should be used.*

Basic Health Program

The creation of a Basic Health Program (BHP) offers opportunities and challenges to the Commonwealth that must be carefully considered. As outlined in our exchange principles:

> *Principle 23: VAHP supports Virginia seeking creative solutions in addressing the needs of lower income individuals in the exchange.*

Frequent changes in eligibility status between Medicaid and the exchange are expected. This churning between eligibility designations has the potential to cause considerable confusion among consumers. There are also valid concerns that affordability may reduce the number of lower-income individuals who participate in the exchange.

Creation of a BHP for individuals between 133% and 200% FPL may help address some of these concerns. A BHP could create a more seamless system for individuals transferring in and out of Medicaid. A majority of Medicaid participants now receive their care through a managed care organization (MCO) or would beginning in 2014. If the state contracted with MCOs for the BHP this would provide for some additional continuity. In addition, this structure would better match with the FAMIS program for children, which currently provides coverage for children up to 200% FPL.

However, there are disadvantages to creating a BHP that are important to consider as well. By creating a BHP, the state would siphon individuals from the pool of potential exchange participants. This would increase the volatility of the exchange market. Also, by creating a new entitlement program, additional administrative costs would be incurred.

As Virginia looks to provide coverage options to this newly eligible population, it is critical that we carefully balance the goal of providing health coverage to the greatest number of people with the consequences of creating a new government program.

We look forward to further discussing the options involved in the establishment of Virginia's health insurance exchange. VAHP is happy to serve as a resource as you address the issues raised by state and federal health reform efforts. Please contact VAHP if you have any questions or concerns.

Best regards,

John Fleig
Chairman
Executive Committee

CC:
Doug Gray, VAHP Executive Director
Reggie Jones, VAHP Legal Counsel

Code of Virginia Insurance Statutes Related to Financial Solvency and Quality

Financial Solvency (BOI)

38.2-1300	Annual statements
38.2-1301	Additional reports
38.2-1301.1	Material transaction disclosures
38.2-1302	Extension of filing time
38.2-1303	Printed forms to be filed by insurers; certificates to domestic insurers
38.2-1304	False statements, reports, etc., deemed a Class 5 felony
38.2-1305	Voluntary reports
38.2-1306	Reports to be open to public inspection
38.2-1306.1	Insurance companies' analyses confidential
38.2-1306.2	Valuation of investments and other assets
38.2-1306.3	Nonadmitted assets
38.2-1307	through 38.2-1309
38.2-1310	Description unavailable
38.2-1310.1	Description unavailable
38.2-1311	Valuation reserves
38.2-1312	Unearned premium reserves
38.2-1313	Loss records
38.2-1314	Loss or claim reserves
38.2-1315.1	Actuarial statements of opinion, reports, memoranda, and summaries
38.2-1317	Examinations; when authorized or required
38.2-1317.1	Examinations; nature and scope
38.2-1317.2	Market analyses confidential
38.2-1318	Examinations; how conducted
38.2-1319	Expense of examination
38.2-1320	Examination reports; general description
38.2-1320.1	Submission of examination report
38.2-1320.2	Filing of report on examination
38.2-1320.3	Examination reports; orders and procedures
38.2-1320.4	Publication and use of examination reports
38.2-1320.5	Confidentiality of ancillary information
38.2-1321	Records of examination preserved
38.2-1321.1	Immunity from liability

Quality (VDH)

32.1-137.1	Definitions
32.1-137.2	Certification of quality assurance; application; issuance; denial; renewal
32.1-137.3	Regulations
32.1-137.4	Examination, review or investigation
32.1-137.5	Civil penalties; probation; suspension; restriction or prohibition of new enrollments to managed ca...
32.1-137.6	(Effective until July 1, 2014) Complaint system
32.1-137.7	(Effective until July 1, 2014) Definitions

32.1-137.8 Application to and compliance by utilization review entities
32.1-137.9 (Effective until July 1, 2014) Requirements and standards for utilization review entities
32.1-137.10 Utilization review plan required
32.1-137.11 Accessibility of utilization review entity
32.1-137.12 Emergencies; extensions; access to and confidentiality of patient-specific medical records and info...
32.1-137.13 (Effective until July 1, 2014) Adverse determination
32.1-137.14 (Effective until July 1, 2014) Reconsideration of adverse determination
32.1-137.15 (Effective until July 1, 2014) Adverse determination; appeal
32.1-137.16 (Effective until July 1, 2014) Records
32.1-137.17 Limitation on Commissioner's jurisdiction

OptimaHealth

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Virginia Beach, Virginia 23462
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Thursday, August 25, 2011

Cindi B. Jones, Director
Virginia Health Reform Initiative
Office of the Secretary of Health and Human Resources

Len M. Nichols, Ph.D., Director
Center for Health Policy Research & Ethics
George Mason University

RE: Written Comments on the August 12, 2011, Third Background Memorandum on Health Benefit Exchange Issues

Optima Health appreciates the opportunity to respond to the third memorandum focused on preparations for potential health benefit exchange legislation for the 2012 General Assembly. As a Virginia-based health plan covering 420,000 members and a service of Sentara Healthcare, we are in a unique position to speak to health reform and exchanges as an insurer, employer and provider-sponsored organization. In addition, Optima Health is one of Virginia's oldest and largest Medicaid managed care organizations with almost 155,000 members. Given our history as one of the first Virginia health plans to achieve an "excellent" accreditation by the National Committee for Quality Assurance (NCQA), we believe that Optima is well positioned to offer Virginians access to high quality private insurance coverage -- one of the underpinnings of an effective health benefit exchange (HBE).

Facilitator Exchange Model – The Best Solution for Virginia

As Virginia continues to refine its vision and plan for the HBE, Optima Health supports a facilitator exchange as the best solution to ensure creative, transparent and market-driven solutions. A facilitator exchange can enhance consumer choices while improving quality and access for both the small group and non-group insurance markets. As outlined in the Virginia Association of Health Plans (VAHP) guiding principles, a facilitator exchange would offer Virginians a well-balanced model comprised of four equally important components:

1. A focus on clinical quality and customer experience
2. Increased access to a network of quality providers
3. Financial stability and stewardship
4. Adherence to PPACA regulations

A facilitator HBE will focus on defining criteria within the exchange. It will:

- Acknowledge the capacity of Virginia government entities and the role of current regulation and legislation to manage the certification of qualified health plans

(QHP). Entities such as the Bureau of Insurance (BOI) and the Virginia Department of Health are well positioned to administer the federal insurance market reforms under PPACA and to continue oversight of the industry. The goal will be to minimize regulatory duplication, consumer confusion, market disruption as well as administrative expense.

- Leverage existing state, federal and industry standards and assessments when establishing the criteria by which QHP's will be evaluated. For example, PPACA requires QHPs maintain an external, national accreditation, like accreditation from NCQA, and the legislature has already given the BOI statutory authority to administer PPACA insurance market reforms.
- Expect plans to maintain the quality and controls to ensure networks of providers and meet access requirements like Managed Care Health Insurance Plan (MCHIP) regulations administered by the Virginia Department of Health.
- Maintain financial stability, reporting and transparency requirements through quarterly and annual filings with the BOI and other agencies.
- Satisfy market conduct requirements for advertising and member materials as well as regular audits of health plan business practices.
- Maximize choice and competition by allowing all qualified health plans (QHP) that meet exchange standards to participate.
- Encourage product diversity and creativity without limiting choices within the "metallic" options and the QHP.
- Require all QHPs to meet the same financial, quality, and access standards established by the BOI and Department of Health for a health insurance carrier and a third party administrator whether they are domiciled inside or outside of the Commonwealth.
- Expect coops and other buying coalitions to meet the same QHP standards

Scope of the Exchange -- Policy Maker or Policy Administrator

Optima Health supports the Governor and the General Assembly as the ultimate policy makers in Virginia through legislation. As an advocate of a facilitator exchange, we recognize the role of the legislature is to set policy that the exchange will then administer. Consequently, we suggest that exchange authority be limited to inside the exchange exclusively and that it should not extend beyond what is legislated and/or regulated today. Anything more or different must come before the General Assembly for approval.

The creation and implementation of an exchange will require focused and considerable attention if we are to meet the operational readiness deadline. Consequently, administering the exchange should be the primary focus of the entity and the executive director. Expanding oversight outside of the HBE, as is suggested in the memo, further deflects attention from this priority. Today, the insurance industry is regulated and managed by a number of government bodies as well as the General Assembly. It is unnecessary for the HBE to expand its purview. Nothing should deflect attention if we are to be ready in 2013 and avoid a default to a federal exchange.

The Basic Health Program

The creation of a Basic Health Program (BHP) offers the Commonwealth an opportunity to expand coverage to a medically underserved population. How the program will be implemented and function within the exchange will require careful consideration by the Commonwealth, especially given the challenges of implementing the HBE simultaneously. Optima Health has supported Virginia's Medicaid and FAMIS programs for more than 15 years, and we understand the complexity of expanding coverage to individuals between 133% and 200% of the federal poverty level (FPL). Continuity of care between Medicaid and the BHP will be important as individual income changes. By contracting with the current Medicaid managed care plans, the transitions in and out of eligibility and between programs could be minimized. The HBE could leverage DMAS expertise in managing enrollment and eligibility as well as health plan contracting for the BHP.

Establishment of the BHP carries other risks like the erosion of the exchange risk pool as these enrollees move into the program and out of the exchange, which Optima Health finds troublesome, especially if provider reimbursements are based on government program fee schedules. The presence of a BHP with its overall reduced cost may persuade small groups from continuing to offer private insurance for their employees.

In addition, lower provider payment rates may limit provider participation in the program. Today, provider reimbursements under Medicaid and Medicare do not cover the total cost of care. As Virginia weighs its plan to expand coverage to these individuals, they must recognize the financial impact on physicians and hospitals when defining reimbursement levels. Such an unintended consequence will erode not enhance access to care.

Managing Risk and Cost -- Limiting Enrollment Periods

Optima Health supports the establishment of an annual election period. Without an enrollment period, adverse selection would severely compromise the affordability and ultimately the financial stability of the exchange.

The HBE should permit enrollment outside the annual election period by clearly defining what constitutes a special election period, such as "life events" like marriage and the birth of a child. The HBE must set controls around qualifying events that require individuals whose coverage ends to purchase insurance within 30 days or wait until the next enrollment period. With or without the individual mandate, an annual enrollment period encourages more individuals to enroll rather than wait until a medical emergency to seek coverage.

Optima Health appreciates the opportunity to provide comments on this third memo from the Virginia Health Reform Initiative Advisory Council and Task Force. We offer our support as the Commonwealth considers the opportunities of an exchange and a Basic Health Program -- to promote competition, to encourage creativity, to ensure quality and to expand coverage for Virginians.

Please contact us with any additional questions you may have.

Sincerely,

Megan Philpotts Padden
Vice President, Government Programs

August 25, 2011

Cindi B. Jones, Director
Virginia Health Reform Initiative, Office of the Secretary of Health and Human Resources
1111 East Broad Street
Richmond, VA 23219

Len M. Nichols, Ph.D., Director
Center for Health Policy Research and Ethics, George Mason University
4400 University Drive, MSN 2D7
Fairfax, VA 22030

Submitted Via Email

RE: Comments on August 12 Memorandum on Preparing for Potential 2012 Health Benefit Exchange Legislation

Dear Ms. Jones and Dr. Nichols:

UnitedHealth Group is pleased to provide the State of Virginia with our comments on the memorandum focusing on preparing for potential 2012 Health Benefit Exchange legislation, issued August 12, 2011.

UnitedHealth Group is dedicated to making our nation's health care system work better. We serve more than 75 million Americans (over 525,000 in Virginia), funding and arranging health care on behalf of individuals, employers and governments, in partnership with more than 5,300 hospitals and 730,000 physicians and other health care professionals. Recognized as America's most innovative company in our industry by *Fortune* magazine, UnitedHealth Group brings innovative health care to scale to help create a modern health care system that is more accessible, affordable and personalized for all Americans. It is this experience that is the basis upon which we offer the following comments to ensure that innovation and flexibility continue to thrive in the health care marketplace.

Summary of Comments

Our comments focus on the decisions that the Commonwealth must make regarding Health Benefit Exchanges, as outlined in the memorandum in Section Five and Section Six. We agree with the recommendation of the Virginia Health Reform Initiative Advisory Council that a goal of the Exchange is to maximize choice, innovation, and the number of competing qualified health plans, with transparency regarding cost and quality.

Section Five: Decisions to Address

Virginia-Run Exchange

We believe that a Virginia-run Exchange would be most responsive to characteristics unique to the Commonwealth, including the specific dynamics of the individual market, small group market, and public programs. Uniform federal standards should be utilized in areas where variation at the state level would add unnecessary complexity, such as risk adjustment mechanisms, quality improvement measurements, and uniform data transaction standards. The Exchange should avoid duplication of existing regulatory functions regarding rate review, licensing, and market conduct, and should rely to the extent possible on existing review standards established by national accreditation agencies – such as NCQA – for use in the health plan certification process.

Governance

We believe that Exchange governing boards will benefit from broad constituent representation from a wide range of stakeholders, including health plans, consumer representatives, employers and providers. Each of these stakeholders brings a unique perspective and expertise to the oversight of the Exchange to ensure that it accomplishes its goals by taking into account the input of all affected interests. We also believe that establishing the Exchange as an independent public authority will both promote transparency and limit politicized decision-making, ultimately benefiting consumers and helping to stabilize the health insurance marketplace.

Health Plan Participation

Ideally, Exchanges should enhance competition, promote ongoing innovation, and increase consumer choice. To best achieve these goals, we believe that all qualified health plans should be permitted to participate in the Exchange. Participating health plans should be encouraged to differentiate their plan offerings to appeal to a wide variety of consumers with different needs and preferences, while remaining consistent with federal standards regarding specified actuarial values. For example, at a particular actuarial plan value (e.g., Silver), some consumers might wish to purchase a high deductible health plan that would be compatible with a health savings account, while others may prefer a plan that offers more first-dollar coverage of pharmacy benefits and lower deductibles.

Separate Individual and Small Group Risk Pools

We believe that maintaining separate individual and small group Exchanges and markets for rating purposes is important. The individual market generally has a higher risk profile than the small group market, presenting a greater potential for adverse risk selection and inherently higher administrative costs for individual coverage compared to small group coverage. Small groups have different eligibility, enrollment, and general administration needs than individuals, and employers with more than 20 employees generally require a different type of customer support service. A likely result of combining the two markets would be to increase the rates for small groups, which could destabilize the small group market. Maintaining separate risk pools also has the potential to encourage a full spectrum of participating health plans that have core competencies in dealing with the distinctly different Exchange populations.

States may wish to share Exchange information technology infrastructure for the individual and small group Exchanges to achieve administrative efficiencies, but the Exchanges and markets should remain separate.

Small Group Definition

We believe that Exchanges should select 50 employees as the initial size limit for the small group market. The 51+ employer group market is already very competitive and enjoys significant market leverage. Groups over 50 employees typically have the option to self-insure their benefits, and it is reasonable to expect that the lowest cost groups would opt to self-insure and the highest cost groups would find the community rates within the Exchange to be most attractive, making products within the Exchange increasingly more expensive for those small groups electing coverage.

Limiting the small group market to groups of 2-50 will also minimize market disruption and avoid overtaxing Exchanges' administrative systems as they get up and running.

We concur with the recommendation in the memorandum to have the same small group definition inside and outside the Exchange to limit adverse selection issues.

Exchange Funding

We believe Virginia should consider the imposition of user fees for those purchasing coverage through the Exchange, similar to the fees successfully established by other state Exchanges to support their ongoing operations. If other assessments are considered to support the Exchange, we believe they should be broad-based and levied on all health care industry participants who benefit from the Exchange, including providers, health plans, employers, agencies and other constituencies.

Benefit Mandates

The Patient Protection and Affordable Care Act (PPACA) requires that states mandating the coverage of certain benefits above what is federally required in 2014 reimburse the Exchange plans (or their enrollees, as applicable) for the additional costs associated with those benefits. Virginia will need to pay these costs, so mandating additional benefits beyond the essential benefits package will need to be considered along with the Commonwealth's other spending priorities.

Market Outside the Exchange

The provisions in the PPACA that protect against adverse selection tend to make the adoption of additional rules unnecessary. Specifically, requiring that all of the same rules apply to plans sold inside and outside the Exchange or requiring that the same plans be sold inside and outside the Exchange without exception would likely serve to reduce consumer choice and competition. For example, some licensed health plans may not meet the requirements to become qualified health plans (QHPs). A rule that these plans must meet the QHP requirements to compete in the outside market could theoretically exclude them from competing in the Commonwealth. Regarding plan design requirements, we believe that Exchanges should promote innovation and increase consumer choice. If a state does impose any design restrictions on Exchange plans, these same limits should not apply in the outside market.

The PPACA already provides a number of mechanisms to mitigate adverse selection against an Exchange. This includes the equal application of health care reform requirements to insurers operating inside as well as outside the Exchange, including:

- Adjusted community rating rules (adjusted only by age, tobacco use, geography, family size)
- Individual and small group plans must cover the same essential health benefits
- Limits on individual out-of-pocket cost-sharing limits
- Treating all individuals as part of one risk pool (same for small group enrollees)
- Charging the same premium rates for a plan offered inside and outside the Exchange
- The operation of the risk adjustment and reinsurance programs

Perhaps the most significant protection against adverse selection against the Exchange is the fact that federal subsidies are only available through the Exchange. Ultimately, the viability of the non-group market will be highly dependent on the development of open enrollment rules, inside and outside the Exchange, that encourage consumers to obtain and maintain continuous coverage.

Section Six: Basic Health Plan

We believe that it would be prudent for Virginia to thoroughly evaluate the Basic Health Plan (BHP) option. This will be an important decision to make early in the process, as it will impact the planning and design of the Exchange.

Nationally, it is anticipated that the majority of purchasers on the Exchange will be highly subsidized, lower income, ethnically diverse and may share significant demographic similarities with Medicaid consumers. It will be important to evaluate these national findings in relation to the Commonwealth to determine the number of Exchange-eligible consumers, their demographic characteristics, and those between 133-200% of the Federal Poverty Level (FPL).

Consumers should be afforded the same level of protection whether in a BHP or in an Exchange plan. Should Virginia pursue the BHP option, participating plans should be certified, with consistent standards for capitalization and financial solvency for all plans seeking certification and participation requirements similar to those required for Qualified Health Plans in the Exchange.

Thank you for your thoughtful consideration of our comments. We would be pleased to provide additional data and information to supplement this letter.

Sincerely,

John E. Fleig
COO Mid Atlantic Health Plan
UnitedHealthcare

National Association
of Health Underwriters
America's Benefits Specialists

August 26, 2011

Via Electronic Transmission

Cindi B. Jones
Director Virginia Health Reform Initiative,
Office of the Secretary of Health and Human Resources

Len M. Nichols, Ph.D., Director
Center for Health Policy Research and Ethics, George Mason University

Dear Ms. Jones and Dr. Nichols:

The National Association of Health Underwriters (NAHU), and our affiliate, the Virginia Association of Health Underwriters (VAHU), are professional associations that represent more than 100,000 health insurance agents, brokers and employee benefit specialists from all across America. On behalf of both associations, please accept these comments on the Virginia Health (VHRI) Advisory Council and Task Force's *Third Background Memorandum on Health Benefit Exchange Issues* : *Preparing for Potential 2012 Health Benefit Exchange Legislation.*

Brief Executive Summary:

Governance:

NAHU would suggest looking at the Colorado Exchange legislation for guidance. That legislation was provided to VHRI previously. Appointments would be made both by the Governor and the General Assembly. The Colorado model regarding Board composition states:

Each person appointed to the Board should have demonstrated expertise in at least two, and in any case should have demonstrated expertise in no less than one, of the following areas:

1) Individual health insurance coverage
2) Small employer health insurance
3) Health benefits administration
4) Health care finance
5) Administration of a public or private health care delivery system
6) The provision of health care services
7) The purchase of health insurance coverage
8) Health care consumer navigation or assistance
9) Health care economics or health care actuarial sciences
10) Information technology, or
11) Starting a small business with fifty or fewer employees

Policy Directions:

- Create a single administrative structure but have separate underlying infrastructure and risk pools within the HBE. Non-group and small group markets are separate and distinct markets.

- Virginia's exchange should remain simple, create a competitive environment of choice and act as a "facilitator" or "clearinghouse." Again, we suggest looking at the Colorado legislation for guidance.

- Allow all plans that meet the qualified health plan (QHP) standard in PPACA to participate.

- Define small group as 1-50. Conform small group definitions inside and outside of the exchange. Revisit in 2015.

- Utilize agents inside and outside of the exchanges and compensate them at the prevailing market rate.

- Require Navigators who advise exchange enrollee to be licensed as producers and maintain "Errors and Omissions" insurance.

- Preserve the markets outside of the exchange.

- Do not create a Basic Health Plan (BHP) in Virginia.

Enclosed is a more comprehensive discussion of NAHU's recommendations and positions that will help clarify our brief summation above.

NAHU and VAHU appreciate this opportunity to review the memorandum and provide feedback. If you have any questions, or would like additional information, please do not hesitate to contact me at either (703) 276-3817 or jwaltman@nahu.org or contact Susan Rash at 804-678-5056 or SRash@BBandT.com .

Sincerely,

Jessica F. Waltman

Jessica F. Waltman

Senior Vice President, Government Affairs

National Association of Health Underwriters

Susan Maley Rash

Susan Maley Rash, CEBS, REBC

Virginia Association of Health

Underwriters

National Association of Health Underwriters

America's Benefits Specialists

August 26, 2011
Via Electronic Transmission

Cindi B. Jones
Director Virginia Health Reform Initiative
Office of the Secretary of Health and Human Resources

Len M. Nichols, Ph.D., Director
Center for Health Policy Research and Ethics, George Mason University

Dear Ms. Jones and Dr. Nichols:

The National Association of Health Underwriters (NAHU), and our affiliate, the Virginia Association of Health Underwriters (VAHU), are professional associations that represent more than 100,000 health insurance agents, brokers and employee benefit specialists from all across America, including approximately 3,000 from the Commonwealth of Virginia. On behalf of both associations, please accept these comments on the Virginia Health Reform Initiative (VHRI) Advisory Council and Task Force's *Third Background Memorandum on Health Benefit Exchange Issues*: *Preparing for Potential 2012 Health Benefit Exchange Legislation.*

Additional Comments Clarifying our Brief Executive Summary

The members of NAHU and VAHU service the health insurance policies of millions of Americans and work on a daily basis to help both individual consumers and large and small employers purchase, administer and utilize health insurance coverage. Consequently, we have a profound interest in the development of any potential health benefit exchange in Virginia and any related legislation. We are pleased to have this opportunity to offer comments as to what potential exchange legislation should address.

As the Advisory Council and Task Force prepare for potential exchange legislation, we believe that it is of critical importance that any such measure should cover how a Virginia exchange will provide consumers with access to licensed health insurance agents outside of the navigator programs, and also that existing state laws concerning health insurance producer licensure and accountability are upheld and applied equally to all individuals who facilitate enrollment in qualified health plans.

NAHU and VAHU believe that exchanges should always include an option for participating individuals and businesses to utilize a certified, state-licensed and independent agent/broker for assistance with their exchange-based coverage. Current state law assumes that all licensed health insurance agents and

brokers can sell and service all health insurance policies offered in the state, which would assume inclusion of exchange-purchased policies. Furthermore PPACA specifically establishes that traditionally compensated health insurance agents and brokers be allowed to enroll individuals and group plans in exchange-based products and assist with subsidies for eligible individuals outside of the PPACA-required Navigator program. PPACA also requires every exchange to have a Navigator program to facilitate health plan enrollment, and agents and brokers are specifically listed by the law as one of the groups that may be navigators. However, the law also stipulates a compensation/financing method that conflicts with traditional agent compensation structures and it may be difficult for agents and brokers to serve as Navigators and also maintain their existing businesses and serve current clients, many of whom may not even be eligible to purchase coverage through an exchange. Therefore, we believe that the Navigator program should only serve as a supplement to certified agents and brokers, who can work directly with both individual and group health insurance exchange consumers in order to make sure that their purchasing needs are being met and that their insurance policies are well serviced after the point of sale, and that any exchange legislation should provide for access to traditional health insurance agents and brokers.

Since it is the professional role of our members to provide consumers with accurate information about their health coverage options, exchange participation is a natural fit. In fact, all successful state-level private purchasing pools and exchanges have elected to utilize the services of agents and brokers for this reason, including both the Massachusetts Connector and the Utah Exchange. Preexisting state pools that did not use agents initially, like the Health Insurance Plan of California (HIPC), which was the longest-running state public purchasing pool to date (operational from 1993-2006), quickly found that the active participation of licensed agents and brokers was the key to the pool's enrollment success. Similarly, the federal government's Preexisting Condition Insurance Plan recently decided to use and traditionally compensate health insurance agents, in hopes of increasing its meager enrollment. In just one week, several thousand agents have already signed up nation-wide to assist health insurance consumers with serious medical conditions find coverage.

We also believe that health benefit exchange legislation should establish that health insurance agents and brokers working outside of the navigator program must be compensated at prevailing market rates established by health insurance carriers offering coverage in the state. This standard is what is used to compensate health insurance agents and brokers in both the Utah Exchange and the Massachusetts Connector. It was also the standard used in California's HIPC and all other state-level purchasing pools both public and private. When the federal PCIP Program just recently realized it needed to both use and compensate agents and brokers for their services, they too conducted a survey of all other state high-risk pools to see how they handled agent compensation. Using the survey data, the PCIP program determined that it should pay slightly more than the national average rate to ensure adequate producer participation in helping to enroll people and attract them to the PCIP plan.

Dr. Nichols has often commented during the VA proceedings that failure of a state exchange would be signified by no or low enrollment. Fairly compensated agents and brokers will ensure exchange success by bringing individual and businesses to the exchange, and more importantly, ensuring their continuous coverage and health plan service. Health insurance agents and brokers work on a daily basis to help individuals and employers of all sizes purchase health insurance, use their coverage effectively and make sure they get the most out of the benefits they have purchased. They design benefit plans, explain coordination issues of public and private benefits to individuals/employees, explain how the interplay of existing federal and states law work, and solve problems that may occur once coverage is in place. They also help employers of all sizes ensure compliance with state and federal laws and serve vital human resource functions for millions of American small businesses. They assist with claims and billing issues,

which may include interacting with providers to correct coding issues. Their active assistance means that consumers' needs are addressed quickly, usually without the need to use the formal appeals process. Consumers' need for help in all of these areas will only increase as health reform is implemented, and these areas of assistance are way beyond the bounds of the Navigator program, which will need to be state-financed.

The private market has years of experience in setting up exchange models, and with agents', brokers' and carriers' knowledge, exchanges will be able to minimize start-up costs. Agents and brokers can help an exchange anticipate consumer questions in advance and accelerate the program's start-up success. In addition, they will serve as a valuable resource to employers that operate in multiple states and may be navigating overlapping and varying exchange rules. Employers with multiple state exposures have issues arranging coverage currently. Their need for professional assistance will only increase with the addition of exchange-based coverage options.

The use of agents and brokers also will help reduce the long-term operational costs of any exchange. The Commonwealth does not have the staff, resources or budgets to handle thousands of calls from confused citizens and employers about coverage options, subsidies, claims issues, etc. Every call that an agent takes and handles in one less the Commonwealth will need to deal with. In addition, because it is the professional agent's job to maintain client satisfaction not just at the point of sale, but throughout the life of each insurance policy, major health insurance carriers report that policies originated by independent agents have better client satisfaction and retention rates, as well as fewer issues with health insurance claims.

However, to ensure that the advisors participating in the exchange are well-qualified and accountable to state-level consumer protection standards, it should be specified that all individuals and entities selling coverage or providing coverage option advice to consumers through any exchange should be subject to existing state insurance licensure and continuing education requirements, as well as all other applicable state-based regulations. This would include both traditionally compensated health insurance agents, as well anyone else who helps "facilitate enrollment in qualified health plans," which is one of the PPACA-specified duties of a navigator. Anything less would be a roll-back of critical existing state consumer protections.

Unless subject to strict oversight, such as the regulatory control the Virginia Bureau of Insurance has had over health insurance producers for decades, the new Navigator program could be a potential breeding ground for scam artists and fraudulent actors. Unfortunately, there is ample evidence of what bad can happen when federal health insurance programs do not provide for an adequate level of state consumer protection oversight. The initial year of the Medicare Advantage program and the longstanding experience of sham MEWA plans are two telling examples. Previously uninsured consumers who may be enrolled in coverage and subsidies at the community level are very vulnerable and will be in need of licensed and professional assistance.

Requiring that navigators who advise exchange consumers on health insurance options be licensed as producers in the state is also the most expedient way to ensure that all health insurance exchange clients receive equal protection of their private financial and health information. Unfortunately, identity theft is the most common crime that occurs in our country, and exchange navigators assisting in qualified health plan enrollment would have access to a great deal of sensitive identifying information, such as social security numbers.

It is NAHU and VAHU's view that exchange navigators should be required to maintain professional "errors and omissions" insurance, as health insurance agents and brokers do. This is a critical consumer protection. Health insurance is a financial protection product and there can be extreme financial consequences to the consumer if a mistake is made, even by the most well-intentioned advisor. In addition, we feel that navigators, if used to advise individuals on their health insurance options, should be limited to entities with prior experience in this area, such as the SHIPs that provide seniors with assistance relative to the Medicare program.

Beyond that, NAHU and VAHU believe that the health insurance exchanges will represent a new purchasing environment that is different than anything existing in today's marketplace. To make sure exchange consumers are well served, we feel that all agents and brokers, as well as navigators, who would like to help consumers understand their exchange-based coverage options should be required to complete an annual exam-based exchange specific certification process. Since most experts predict that a high volume of exchange consumers will transition back and forth between the Medicaid program and private insurance products, it is critical that this certification program address both private coverage options and public assistance and subsidy-eligible options to ensure that all licensed producers and navigators are familiar with all coverage choices available to consumers.

Trained advisors will help increase access and overall coverage rates by helping individuals determine what options would serve them best, and a uniform advisor certification requirement will ensure continued accountability and consumer protection. The federal long-term care partnership program provides a model for such a certification process. In addition, the Utah Exchange currently includes a certification program, as do producer-based state-level subsidy programs operational in Oregon and Oklahoma.

However, an exchange certification program should always be viewed as a supplement to state-level producer licensure and accountability standards. Certification can in no way be a replacement or an acceptable alternative for licensure should an individual working or volunteering for a navigator entity cross the threshold of what triggers the need for licensure in Virginia today—soliciting, selling or negotiating insurance. The exchange legislation should acknowledge that it in no way preempts existing state laws regarding producer licensure and the concrete consumer protections they provide. Everyone seeking insurance should receive the same regulatory protection, regardless of how they purchase their coverage. Requiring the use of licensed insurance professionals to help facilitate enrollment guarantees that all consumers will be protected on an equal basis should be a part of any Virginia exchange legislation.

Regarding the some of the other major decisions to be considered by the exchange, NAHU and VAHU believe a primary concern needs to be the cost of coverage. As agents and brokers who assist people with health insurance marketplace choices every day, we know that price discovery and transparency will be good for consumers and for our clients. But the survey VHRI commissioned in July showed, the number one concern for employers in Virginia today is cost—specifically the potential cost of exchange-based premiums. A stated goal is to lower premium growth trend off baseline by 10% by 2020. But how is that baseline being determined? And what exactly will lower costs for small employers in the state? While our association believes that it is imperative to reduce the cost of health insurance, we also know that premium costs are driven by the cost of medical care and the number of covered services in a policy and expected utilization. We are unclear as to how PPACA generally, or in a potential Virginia exchange specifically, will lower costs for all business health care consumers. Instead we see costs only rising due to new rating methodologies, increased mandated benefits and plan design limitations, and many, many

new compliance costs. We anticipate there will be "winners" who will see their premiums decrease but there will also be "losers" who will see their costs increase, sometimes dramatically.

It's not just small business consumers that have cost concerns. Any exchange board will need to confront the reality that exchange policies will result in price shock for many individual market consumers in the state today. Price Waterhouse in their presentation to VHRI in July noted that currently in the individual market, an estimated 40% of the existing covered individuals had coverage that will not meet the minimum actuarial value expected under PPACA. That means 40% will have to enhance their coverage to meet minimum standards and increase premium payments. Those Virginians may not be happy -- unless of course they qualify for federal subsidies to support their premiums, but that will only be the case for some, not others.

Another area where we believe the exchange board will need to focus is ensuring enrollment. One of the VHRI's stated goals for an exchange is to enroll 3% of Virginians by 2016. However, the exchange board will need to concentrate efforts to target those who were actually previously uninsured. The exchange will need to take extreme steps to ensure that the program does not simply move small groups and individuals from outside of the exchange to inside of the exchange so they can seek government subsidized coverage. We feel the VHRI should set a specific goal relative to reducing our state's number of uninsured.

Based on the Urban Institute's presentation to VHRI in July there are 1,038,437 uninsured (total nonelderly) in the state. Of those uninsured, 51% will likely be Medicaid-eligible under the new expanded income guidelines. This leaves approximately 500,000 uninsured that will need to be drawn into the exchange as individuals or covered by their employers, either via the SHOP exchange or traditional private market. We believe that VHRI needs to develop a specific plan to target these individuals, and that agents working the exchange could provide a key role in helping these people find the most appropriate coverage option,

Keeping employers in the system also needs to be a priority. We have concerns that many employers, particularly small employers, will potentially drop coverage, for a variety of reasons. These include complexity of the exchange and other PPACA-related compliance burdens, complexity of determining whether or not they provide adequate coverage, a large number of employees who may qualify for individual subsidies, and ineligibility for participation in the SHOP exchange (which is a real possibility for many smaller firms with a large number of part-time workers). Again, we believe that use of traditional agents beyond the navigator program in a Virginia exchange will be key to ensuring that employers remain in the business of providing their employees with quality health coverage and helping to finance the cost of that coverage.

Finally, the Advisory Council and Task Force have requested specific comment as to whether or not Virginia should establish a Basic Health Plan (BHP) to serve lower income individual exchange consumers. NAHU and VAHU believe that Virginia should not create an additional government-run component to its exchange, and instead should allow all non-Medicaid eligible consumers to purchase all private coverage options available through the private marketplace using the exchange-based premium tax credit subsidies. A health benefit exchange is an untested concept and there are many, many components our state will need to complete in order to create a PPACA-compliant exchange by the January 1, 2014 operational deadline. As such, we believe the Commonwealth should begin its exchange as simply as possible, placing all focus on the mandatory components first. We can always grow and expand upon programs and functionality as time, need and market experience dictate. Furthermore, creating a new and additional government-run program will just tap already strained

financial and operational resources. Our association also has concerns that separating out populations, as the BHP would do, could undermine the exchange's overall risk-pool, and that there would be a great deal of "churn" between the BHP and the traditional exchange, as income levels, especially with this population group, tend to fluctuate from year-to-year.

NAHU and VAHU appreciate this opportunity to review the memorandum and provide feedback. If you have any questions, or would like additional information, please do not hesitate to contact me at either (703) 276-3817 or jwaltman@nahu.org or contact Susan Rash at 804-678-5056 or SRash@BBandT.com .

Sincerely,

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Senior Vice President, Government Affairs
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Susan Maley Rash, CEBS, REBC
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Anthem

August 25th, 2011

Ms. Cindi B. Jones
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Dr. Len Nichols
Director of the George Mason University Center for Health Policy Research and Ethics
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

RE: Comments on August 12th Memorandum – Preparing for Potential 2012 Health Benefit Exchange Legislation

Dear Ms. Jones, Dr. Nichols and members of the Virginia Health Reform Advisory Council:

Anthem appreciates the opportunity to provide comments on this third and final memo from the VHRI as we prepare for potential 2012 health benefit exchange legislation.

While our detailed comments below address our rationale for supporting several key policy decisions being addressed via legislation, we also want to reiterate what we believe will be the most critical element of any exchange legislation Virginia brings forth. As stated in our response to the second VHRI memo, Anthem firmly believes that our ultimate success in implementing any exchange will be our commitment to design a "facilitator" exchange that will build upon existing state and federal law and thereby mitigate the risk of creating administrative burden, higher costs and less choice for individuals and small employers. The Commonwealth's historical respect for competition and the use of market forces is well known as indicated by their repeated national rankings as one of the business friendliest states. A facilitator exchange model best conforms to this tradition and environment and will maximize choice, competition and health plan participation.

Specifically, a facilitator exchange model would:

- Allow all carriers with plans that meet the qualified health plan (QHP) standards required by the ACA and later promulgated by the Secretary of HHS to be permitted to offer such plans in Virginia's exchange;
- Maximize choice, competition and health plan participation, ensuring that a sufficient number of health plans are available to fit the unique needs of different individuals and small employers, and allow health plans to offer benefit designs of their choice as long as they meet the ACA provisions;
- Allow the market to drive plan participation and enrollment;

- Minimize regulatory duplication, confusion and market disruption; and
- Be prohibited from negotiating insurer premium rates or excluding plans that meet the QHP standards required by the ACA and later promulgated by the Secretary of HHS.

Again, Anthem firmly believes that by acting as a facilitator subject to appropriate federal and state requirements, exchanges can best ensure a sufficient number of health plans are available to fit the unique needs of different individuals and small employers.

Thank you again for this opportunity for comment. Please see our responses below to the key issues posed for comment within Section V of the memo.

Section V. Decisions that could be made by the Legislature, the Governance Structure, and the Director of the Health Benefit Exchange

Major Decisions That Must be Addressed by the General Assembly

1) **To create a Health Benefit Exchange, so that Virginia policy makers will have maximum freedom to shape health insurance markets and health reform in Virginia (HB 2434).**

   Anthem agrees that the Virginia General Assembly should legislate a Virginia Health Benefits Exchange so that it is designed to best meet the unique needs of the Commonwealth. In creating its own exchange, Virginia will be able to take advantage of state flexibility provided under federal law to thoughtfully create an exchange that will work with the needs of its individuals and small businesses and allow the Commonwealth to adapt as market conditions in the state change.

2) **Governance (required by HB 2434)**

   Anthem believes that regardless of the governance structure adopted, (1) it should be cost efficient so as to not unnecessarily add to the cost of exchange products, and (2) Virginia's exchange legislation should ensure that existing state capabilities and efficiencies are leveraged and should make explicit the need for formal, ongoing consultation with key stakeholders relevant to carrying out the activities the exchange is required to conduct under federal law so that the exchange runs efficiently and is able to fulfill its key duties. Such stakeholders should include, at minimum, the following:

   - *Consumers;*
   - *Health plan enrollment experts;*
   - *Department of Insurance representative(s);*
   - *State Medicaid office representative(s);*
   - *Consumer advocates who can assist in involving hard-to-reach populations;*
   - *Providers;*
   - *Small business owners and self-employed persons; and*
   - *Health insurers and HMOs marketing within the state.*

   Further, Anthem submits that in order to truly accomplish both goals, locating the governance of the exchange within the SCC makes the most sense. As an agency that is well-insulated from undue external influence, it is best equipped to take on and maintain a facilitator model. Additionally, it has a proven track record of providing transparency, providing an open forum for public input and providing effective regulatory and operating oversight of the insurance industry.

3) **Major Policy Directions to be set by legislature**

a(i) - Single administrative structure or separate

So long as Virginia's legislation ensures that separate and distinct markets for individuals and small groups are maintained, Anthem is open to and in fact suggests that Virginia create only one exchange, or a "single front door," for administrative efficiencies. This should be specified within legislation.

a(ii) - Within HBE, SHOP vs. non-group pool set separate

Anthem believes it will be critical for Virginia's exchange legislation to make explicit the maintenance of separate and distinct markets for individuals and small groups, regardless of whether or not Virginia decides to consolidate exchanges administratively to gain efficiencies. These separate markets would include separate risk pools, as combining risk pools for the individual and small group markets is likely to lead to higher rates for small groups due to adverse selection. Maintaining separate markets will also allow health insurers to tailor benefit designs to meet the needs of each market, and thus better serve individuals and small employers.

Additionally, Anthem feels strongly that Virginia's legislation should permit plans to decide whether or not to sell coverage to either or both of the markets – inside or outside of the exchange. Carrier choice in this regard will increase plan participation, encouraging competition and resulting in higher quality plans. Further, health plans should be able to continue to offer different products to the different markets to best serve the needs of consumers.

b(ii) - To have discretion to require more than the federal requirements for health plan participation

While Anthem does believe this is an appropriate decision for the General Assembly, Anthem opposes Virginia's exchange legislation imposing, or leaving the door open to imposing, any requirements on qualified health plans within exchanges beyond those required by the ACA. This will ensure that competition and choice are maximized, along with health plan participation in the exchange. Existing regulations are sufficient and any additional requirements on Qualified Health Plans (QHPs) would minimize competition, choice and health plan participation in exchanges. Thus, Virginia's exchange legislation should make explicit that QHPs shall not be required to include more than the federal requirements.

It is important to note that the ACA already adds many new protections for consumers including:

- *Establishes guaranteed issue of health insurance for individuals, beginning in 2014;*
- *Caps small employer deductibles at $2,000 and requires actuarial value over 60 percent;*
- *Establishes exchanges that require plans to be certified for quality and requires prices to be the same inside and outside the exchange, reducing risk selection concerns;*
- *Ensures "essential" health benefits are covered;*
- *Establishes a rate review process, which requires insurers' justification of "unreasonable" rate increases;*
- *Removes lifetime coverage limits;*
- *Phases-out annual dollar limits (until 2014 when the ACA bans them from most plans);*
- *Prohibits arbitrary rescissions of insurance coverage;*

- *Keeps young adults up to age 26 covered under parents' plans, if applicable; and*
- *Provides full coverage (with no cost-sharing) for certain preventive services.*

The ACA also already strongly regulates products to be offered through exchanges by:

- *Requiring all plans to meet one of four actuarial value levels (or be a catastrophic plan only available to individuals under 30); and*
- *Establishing certification criteria for network adequacy, quality improvement, marketing, and other areas.*
- *Anthem therefore believes that creating additional regulation through an exchange authority would be unnecessary and could prove counter-productive, particularly as exchanges first launch.*

b(iii) - To be an "Active Recruiter" of plans to compete inside the HBE

While Anthem agrees that this is an appropriate decision point for the General Assembly, we firmly believe any exchange legislation advanced by Virginia should be explicit in its commitment to design of a "facilitator" exchange—not an "Active Recruiter" exchange—that will build upon existing state and federal law and thereby mitigate the risk of creating administrative burden, higher costs and less choice for individuals and small employers. The exchange should be prohibited from providing any special arrangements to health plans it may "recruit" as the exchange should avoid creating an unlevel playing field amongst insurers. Again, the Commonwealth's historical respect for competition and the use of market forces is well known as indicated by their repeated national rankings as one of the business friendliest states. A facilitator exchange model best conforms to this tradition and environment and will maximize choice, competition and health plan participation.

Specifically, a facilitator exchange model would:

- *Allow all carriers with plans that meet the qualified health plan (QHP) standards required by the ACA and later promulgated by the Secretary of HHS to be permitted to offer such plans in Virginia's exchange;*
- *Maximize choice, competition and health plan participation, ensuring that a sufficient number of health plans are available to fit the unique needs of different individuals and small employers, and allow health plans to offer benefit designs of their choice as long as they meet the ACA provisions;*
- *Allow the market to drive plan participation and enrollment;*
- *Minimize regulatory duplication, confusion and market disruption; and*
- *Be prohibited from negotiating insurer premium rates or excluding plans that meet the QHP standards required by the ACA and later promulgated by the Secretary of HHS.*

Again, Anthem firmly believes that by acting as a facilitator subject to appropriate federal and state requirements, Virginia's exchange can best ensure a sufficient number of health plans are available to fit the unique needs of different individuals and small employers. By engaging in "active recruiting," selective contracting and/or premium negotiation, exchanges will limit the number of plans available to individuals and small employers and

undermine the incentive for plans to develop exchange offerings. While some have argued that an "active purchaser" model is necessary to ensure high value choices for individuals and small employers, Anthem believes that exchanges can meet this goal by creating clear and objective standards for participation by qualified health plans that ensure value. These standards should be applied uniformly to all QHPs seeking to participate, rather than by giving the exchange the authority to design and decide what health plans are available to individuals and small employers. A competitive approach will ensure objective criteria for health plans to meet to be certified, while eliminating potential uncertainty that could dissuade health plans from making the investment to participate and the potential for undue influence that is inherent in an "active purchaser" model.

c. To require risk pools of SHOP and non-group markets to be kept separate

As noted above, Anthem believes it will be critical for Virginia's legislation to explicitly call for the maintenance of separate and distinct markets for individuals and small group (regardless of whether or not Virginia decides to consolidate exchanges administratively to gain efficiencies, which Anthem recommends). These separate markets would include separate risk pools, as combining risk pools for the individual and small group markets is likely to lead to higher rates for small groups due to adverse selection.

Maintaining separate markets will also allow health insurers to tailor benefit designs to meet the needs of each market, and thus better serve individuals and small employers. Additionally, Anthem feels strongly that Virginia should permit plans to decide whether or not to sell coverage to either or both of the markets – inside or outside of the exchange. Carrier choice in this regard will increase plan participation, encouraging competition and resulting in higher quality plans. Further, health plans should be able to continue to offer different products to the different markets to best serve the needs of consumers.

d. To define "small" as 1-50 until 2016 (2016, must go up to 100), starting in 2017, could be larger if legislature/HBE decides to

Anthem believes that Virginia's legislation should limit the definition of small employer to 2-50 or less until 2016. This will allow the exchange time to optimize systems for individuals and smaller groups before extending eligibility beyond that which is required. Further, larger groups have different needs than smaller ones, and tend to be sophisticated purchasers of coverage, so it is unlikely that an exchange designed for smaller employers will be attractive to larger employers.

Permitting groups of 51 and up to purchase coverage on the exchange prior to 2016 will result in earlier recognition of significant market disruption for this segment, leading to adverse selection as healthier groups have greater incentive to self-insure outside of the exchange when faced with more restrictive rating. Further, as groups get larger, they are more likely to have the means to self-insure. This means that there is an even greater increased risk for adverse selection into the exchange as group size increases because healthier groups are more likely to self-insure and less healthy groups are more likely to seek coverage in the exchange.

Lastly, Anthem believes that large employers (those with more than 100 employees) should continue to purchase coverage outside of the exchange, even post-2017, when Virginia would have the option to allow them to purchase coverage on the exchange, and that Virginia's legislation should propose this. Again, larger groups have different needs than smaller ones, and tend be sophisticated purchasers of coverage, so it is unlikely that an exchange designed for small employers will be attractive to larger employers. And, as noted above, larger groups are more likely to self-insure, which will increase the risk for adverse selection into the exchange, increasing costs for all fully insured groups.

h. To set broad goals and accountability mechanisms

The goals of the exchange should be broad, with the overarching goal being to reduce the number of uninsured, while maintaining a functional marketplace in Virginia. These goals should view the market in total and not just focus on the exchange.

i(i) Roles of Agents inside and outside of the exchange

Regarding the role of brokers, Anthem believes they should continue to play an important role in the sale of health insurance inside and outside of Virginia's exchange. This is especially true for the small group market, in which brokers often help small businesses with more than the election of a health insurance plan. Anthem supports health plans maintaining the ability to set broker commissions for sales outside of the exchange and also for coverage sold through the exchange.

Again, Anthem appreciates the opportunity to provide comments on this third and final memo from the VHRI as we prepare to come together for our September meeting. Please feel free to contact me with any additional questions you may have at this time.

Sincerely,

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Director, Government Relations

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August 26, 2011

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RE: IIAV Response to Third Memorandum

Dear Ms. Jones, Dr. Nichols, and members of the Virginia Health Reform Advisory Council:

Hard to believe we're coming up on our September meeting and we first want to thank the VHRAC for all of your work and deliberations on this extremely complicated and potentially divisive issue. We applaud your ability to solicit input from all influence groups and from those most affected.

We remain concerned however that our discussions have not been able to address the overriding issue, and underlying mandate that is driving all of our discussions: The ability to reduce the cost of health care. Speaking as an association representing a wide range of businesses – who both purchase and sell insurance products – little has been addressed to specifically target the underlying causes of the increases of health care costs. Current projections are simply unsustainable.

With this in mind, we would like to address a number of the outstanding and requested issues associated with the HBE. First however, let's address an issue obviously of critical concern to our members.

Should agents be allowed to sell insurance inside the exchange – and should Navigators be licensed?

Call us a bit paranoid, but we remain confused and concerned when the third memorandum repeats the original second recommendation to the Governor – intro and numbers 1 through 10 – from the VHRIAC on page 5 but excludes the concluding paragraph of the ten points (page 68 of the final report):

> *It is the clear sense of the Task Force and of the full Advisory Council that insurance agents, brokers, and consultants play extremely important roles in educating employers and consumers about health insurance options today, and that therefore they should play important roles in all health insurance markets in the Commonwealth in the future.*

We obviously believe that this is an integral part of the recommendations to the Governor and legislature and future deliberations. Moreover, during the last meeting – if we recall correctly – there was a unanimous vote among the VHRIAC that agents indeed should be allowed to sell insurance inside the exchange and this too is no where in the 3rd memorandum. We simply don't believe that these points need to be repeatedly revisited and respectfully request that they be reflected in a final report of the Advisory Council.

Regarding the distinction of agents vis-à-vis navigators:

The Virginia General Assembly has to some degree already ruled on this question with the current Code:

> *§ 38.2-1800 "Agent," "insurance agent," "producer," or "insurance producer," when used without qualification, means an individual or business entity that sells, solicits, or negotiates contracts of insurance or annuity in this Commonwealth. … "Health agent" means an agent licensed in this Commonwealth to sell, solicit, or negotiate insurance as defined in §§ 38.2-108 and 38.2-109, and including contracts issued by insurers, health services plans, health maintenance organizations, dental services plans and optometric services plans licensed in this Commonwealth.*

As mentioned before in our response to the second memorandum, insurance agents are regulated by the Bureau of Insurance, we have to maintain a significant and on-going level of continuing professional education and are personally and corporately responsible for mistakes to the extent that any responsible agent will carry errors & omissions insurance. Moreover, health insurance agents don't have the luxury of only looking at Virginia law. As we've recently learned they have to be intimately familiar with Federal Law such as HIPPA requirements and particularly for example the "Pre-Existing Condition Insurance Plan (PCIP)" which is federally administered and upon which agents receive a fee for placements.

We guess that the public policy question to be applied – just how much do you want the consumer protected when they seek assistance from a Navigator?

We would construe the business of a Navigator to be similar to that of the Department of Medical Assistance Services which does an excellent job of helping consumers – and not that of placing business

with insurers. Consumers should be able to contact the insurers directly or seek the services of a licensed insurance agent who might be in a better position to review insurance contracts.

Insurance agencies deal with the "license line" all the time. They have employees who are both licensed and unlicensed and they know which "line" not to cross without having to refer a consumer to a licensed agent. The Health Benefit Exchange should be no different and frankly if insurers continue to reduce the fees and/or commissions paid to health insurance agents, we're likely to see the need for the HBE to hire licensed insurance agents who are let go from agencies who can no longer afford them – which makes completely no sense from a public policy standpoint.

As to the questions presented in the 3rd memorandum and in no particular order:

What should be the composition of the Board/Advisory Committee?

We believe the Colorado Law Senate Bill 11-200 provides the very best model for this question. As it pertains to the composition of the Board in Colorado they specify:

"Each person appointed to the Board should have demonstrated expertise in at least two, and in any case should have demonstrated expertise in no less than one, of the following areas:

1) Individual health insurance coverage
2) Small employer health insurance
3) Health benefits administration
4) Health care finance
5) Administration of a public or private health care delivery system
6) The provision of health care services
7) The purchase of health insurance coverage
8) Health care consumer navigation or assistance
9) Health care economics or health care actuarial sciences
10) Information technology, or
11) Starting a small business with fifty or fewer employees.

There are further specific details on the appointments (for example the coordination of appointments by the governor and legislature) which we believe could fully apply to Virginia. The Colorado law has been provided to you earlier for your review and consideration.

Facilitator vs. Active Purchaser

We reiterate our position from the 2nd memorandum that Virginia should apply the facilitator model to the HBE. The HBE's role should be to help create a competitive environment in the state and not pick winners and losers. We further believe that you have stated the HBE's role correctly by stating, "some required functions of the HBE – for example, producing an objective ranking of all plans based on costs and quality criteria, operating a Navigator and comparison web-sites to provide unbiased advice about plan choices to potential enrollees, and providing a cost-calculator so that enrollees can estimate their out-of-pocket liability with specific health plans prior to purchasing,". Again, if we're trying to control

costs, if a company can provide insurance that meets the HBE criteria at lower cost…what's wrong with that picture? We seriously doubt that lower costs can be obtained when you anoint the privilege of participating in the HBE to only a select few. If you do, it's not based on reality but on manipulated data.

We agree to the extent possible that the HBE, industry and business community should be an "active recruiter" of insurance companies and that we should continue to announce that "Virginia is open for business." If there are impediments to companies coming into Virginia, they should be eliminated or addressed. What absolutely should not be done is to establish criteria for non-domiciled or located businesses to work inside Virginia at a competitive advantage to firms currently conducting business in Virginia. Enticements need to be equal opportunity.

Roles of agents inside and outside of the HBE

Again, by our definition, agents by their very nature are navigators. At a minimum they assess the needs and wants of the consumer, evaluate the policy coverages of multiple plans from multiple insurers, work with the consumer to evaluate the responses from the insurers, advocate on the consumers behalf additional policy coverages, negotiate terms and provide consumer support once the policy has been purchased (promptly helping to add new employees, or delete employees who resign and answer the myriad of questions employees have on coverages).

In short, you have two roles played by "navigators" and agents, the first of which they cannot receive remuneration: That's the help and assistance provided to evaluate the needs of the consumer and then the binding of coverage. Once you move beyond the assistance, to negotiating price and policy language, then you must be a licensed agent whether you work for the HBE or in an insurance agency.

Regarding payment rules for agents – we can think of nothing more that should NOT be a function of government than that of getting between the contract negotiations of insurance agents and their appointed companies. While insurers – in order to gain some control over Medical Loss Ratio (MLR) applications – have generally slashed and burned agent commissions and fees to the point that many are questioning their ability to sustain a profitable business, getting into the fee or commission setting business is far beyond a core function of government.

The Basic Health Plan

While generally speaking we see the transitional need for the Basic Health Plan, we cannot conceive of the reality of getting legislative approval for a potentially exceedingly new and expensive insurance program. Perhaps the companies who are creating qualified health plans for the HBE can also address the transitional needs of individuals whose incomes fluctuate. Simply put however, if the legislature didn't approve of a proposal for a triad plan paid for by the consumer, business and government, we cannot conceive that they would approve the outlined Basic Health Plan.

These comments are respectfully submitted on behalf of the Independent Insurance Agents of Virginia. We look forward to further discussing these options and comments at your upcoming meeting. If you have any questions in the mean time, please don't hesitate to contact us directly.

Sincerely:

Robert N. Bradshaw, Jr., MAM
President & CEO
Independent Insurance Agents of Virginia

W. Monty Dise
President
Asset Protection Group and member of the Virginia Health Reform Initiative Advisory Council, and
Member of the IIAV Legislative Committee

Founded in 1898, IIAV is part of the nation's oldest and largest associations of independent insurance agents, representing a network of more than 300,000 agents and agency employees nationwide and over 7,000 in the Commonwealth of Virginia. Its members are insurance businesses that offer customers a choice of policies from a variety of insurance companies. Independent agents offer all lines of insurance – property, casualty, life, health, employee benefit plans and retirement products. Web address: www.iiav.com and nationally www.independentagent.com

KAISER PERMANENTE®
Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

August 26, 2011

Cindi B. Jones, Director
Virginia Health Reform Initiative
Office of the Secretary of Health and Human Resources

Len M. Nichols, Ph.D., Director
Center for Health Policy Research and Ethics
George Mason University

Re: Third Background Memo on Health Benefit Exchange Issues

Director Jones and Professor Nichols:

Thank you for seeking input on the *Third Background Memorandum on Health Benefit Exchange Issues*. We have provided extensive comments in two prior letters to you, the latest dated June 29, 2011. This letter will supplement those comments by providing input on: 1) the roles of the Virginia Bureau of Insurance and the Health Benefits Exchange; 2) the optional Basic Health Benefit Plan; and, 3) decisions that should be addressed by the General Assembly and the governance structure of the Exchange.

As we have said in our prior comment letters, Kaiser Permanente believes the development of an Exchange provides Virginia with the opportunity to restructure the small group and individual markets to simplify the purchase of health coverage and increase the value and affordability of the coverage offered. Properly designed, an Exchange can be an important tool to expand consumer choice, support informed purchasing, stimulate value, increase affordability and drive quality improvement. A poorly designed Exchange could destabilize Virginia's health insurance market and increase the cost of coverage

Kaiser Permanente of the Mid-Atlantic States region, provides and coordinates complete health care services for almost 500,000 members through 30 medical office buildings in Virginia, Maryland and Washington D.C. Established in 1980, Kaiser Permanente in Virginia is a total health organization composed of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and the Mid-Atlantic Permanente Medical Group, P.C., an independent medical group that features approximately 900 physicians who provide or arrange care for patients throughout the area.

Roles of the Bureau of Insurance and the Health Benefit Exchange

As we have stated in prior letters, Kaiser Permanente strongly recommends the Exchange should not be housed within the Bureau of Insurance. BOI regulates carriers, enforcing all licensure and solvency requirements as well as maintaining enrollee grievance procedures, and should continue in that capacity. This would include all oversight of insurers that issue Qualified Health Plans, or

QHPs. The role of the Exchange under ACA is different: to determine whether a QHP meets Exchange requirements and to facilitate the purchase of QHPs by consumers.

Kaiser Permanante recommends that the roles of the insurance regulator and the Exchange administrator be kept separate and distinct. While their roles will necessarily compliment each other in many Exchange functions, there should be no overlap in, or duplication of, responsibilities between the two entities. The BOI should continue to focus on its important core regulatory responsibilities. Any new functions required by ACA for the operation of the Exchange should be undertaken by the Exchange entity itself.

The Optional Basic Health Plan

Creation of a Basic Health Plan, or BHP, would add another entitlement program in Virginia with different eligibility and market rules from the commercial market and from Virginia's Medicaid program. Kaiser Permanente has serious questions about the problems that a BHP could cause to the market, and specifically to the Exchange. Some of these concerns were recently expressed by at least one other state exchange board, which requested its state legislature to set aside a BHP proposal as premature, without further study. We believe this caution and deliberation about the BHP is warranted. It should not be implemented in Virginia until it has been studied and reviewed thoroughly.

The success of the Exchange will rely on a large pool of consumers in a competitive marketplace with high quality, affordable health coverage offered by numerous plans. According to some estimates, the BHP will remove between one-third and one-half of consumers from the Exchange, and partition them into a separate entitlement program. Significantly, the individuals who would be separated from the Exchange are the most highly-subsidized income group, and therefore, the most likely to take up coverage. Accordingly, the act of establishing a separate entitlement program for subsidized, low-income individuals could make premiums considerably more expensive for middle-income individuals who would be left behind in the Exchange, with a less-balanced risk pool from which a large number of subsidized individuals has been isolated.

In addition, the core financing of the program will only be effective for low-income consumers if rates paid to providers are significantly lower than rates likely to be paid in the Exchange. Less than adequate rates paid in the BHP may create access problems and further exacerbate cost shifts to commercial purchasers.

A core feature of the ACA is to provide consumers with streamlined and simplified access to health coverage. By establishing a new low-income entitlement program separate from the exchange and from the Medicaid program, the BHP further fragments access to care. If the BHP is established, consumers will move between two and three programs as income changes in the fairly narrow band between 138% and 200% of FPL. This will neither be good for consumers nor good for the Exchange.

Finally, we must note that the U.S. Department of Health & Humans Services has not yet released proposed rules for the BHP. The lack of federal rules creates a high degree of uncertainty that weighs against implementing the Basic Health Plan option at this time. If a BHP is created prior to the release of federal regulations, it may not meet federal requirements which would result in its being ineligible for federal funding.

Decisions made by the General Assembly and the Governance Structure of the Exchange

The *Third Background Memorandum on Health Benefit Exchange Issues* requests comments on which Exchange-related decisions should be addressed by the state legislature and which should be addressed by the Exchange entity. Referring to the chart in the *Third Memorandum* that begins on page 14, Kaiser Permanente believes that the decisions outlined in items 1, 2, and 3 should be made by the General Assembly.

Item 4 which begins on page 15 of the chart relates to the delineation of duties of the Exchange. While ACA clearly requires all Exchanges to undertake specific functions, the General Assembly is the appropriate body to decide whether the duties of Virginia's Exchange should be expanded beyond what is required by ACA.

The second portion of the chart that begins on page 16 is entitled *Major Policy Decisions that Could Be Delegated Entirely to the Board*. Kaiser Permanente believes that all seven items listed there are decisions that clearly should be made by the Exchange's governance structure. Item 6, in particular, is related to choosing the mechanism and approach to implementing risk corridors, reinsurance and risk adjustment. These highly technical topics will require input from insurance experts and actuaries, and should not be subject to the politics of the legislative process. To a large degree, the success of the Exchange will depend on whether the appropriate risk-related mechanisms are chosen and implemented correctly.

Authority for Exchange Flexibility

Item 7 on the chart on page 16 of the *Third Memorandum* provides the Exchange with the authority to adjust market rules if adverse selection threatens the financial integrity and competitive potential of the Exchange. Kaiser Permanente strongly believes that granting the Exchange this authority is of critical importance to its success. The Exchange will need as much flexibility as possible to fulfill its functions and respond quickly to the new market structure that will be evolving in real time. It is reasonable to expect that every decision the Exchange makes will lead to responses in the marketplace, both inside and outside the Exchange. If the Exchange's ability to adapt or counter-respond to those changes is hindered or too closely circumscribed, the Exchange will be prevented from successfully carrying out its market functions.

While it is vital for the state Legislature to establish the policy that the Exchange will be charged with implementing, it is equally vital that the Exchange be given the leeway to act as circumstances warrant. The ACA creates both opportunities and challenges, and whether private companies offer products in the Exchange or not, they will make decisions quickly and act rapidly. The Exchange must also have the ability to keep up with fast-changing market conditions.

Kaiser Permanente sees a tremendous opportunity for the Exchange to provide quality, affordable choices to individual consumers and small employers and we thank you for the opportunity to comment on the *Third Background Memorandum on Health Benefit Exchange Issues*.

Please contact Laurie Kuiper, Senior Director of Government Relations, at 301-816-6480 or Laurie.Kuiper@KP.org to arrange further discussion or if you have any questions. We look forward to working with you on these issues.

Very truly yours,
Ken Hunter
Chief Operating Officer
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

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